Form 113 Revised 2/2000

STATE OF UTAH - LABOR COMMISSION

Division of Adjudication
160 East 300 South, 3rd Floor, P. 0. Box 146615
Salt Lake City, Utah 84114-6615
(801) 530-6800 (800) 530-5090 Fax (801) 530-6333

SUMMARY OF MEDICAL RECORD

(To be completed by treating physician.)

PATIENT NAME:_____ **DOB:**_____ **S.S. #:** _____
DATE OF INJURY:_____ **EMPLOYER:**_____

1. Has patient been released for usual work?_____ What date? _____

2. Has patient been released for light duty?_____ What date?_____

3. Patient was required to be off work from_____ to _____

4. Does patient have a permanent injury?_____ If so, describe fully: _____
   _____
   _____
   _____

5. In case of permanent injury, on what date did or will the patient reach a final state of recovery? _____

6. If there is a permanent injury, give your estimate of impairment in terms of percentage of loss of function:_____
   _____

7. Is there medically demonstrative causal relationship between the industrial accident and the problems you have been treating?
   Yes _____ No _____ Please explain as necessary:_____
   _____

8. What future medical treatment will be required as a result of the industrial accident? _____
   _____

9. What is the percentage of permanent physical impairment attributable to previously existing conditions, whether due to accidental injury, disease or congenital causes? _____
   _____

10. What is the patient's total physical impairment, if any, resulting from all causes and conditions, including industrial injury?
    _____
    _____

11. Did the industrial injury aggravate the patient's pre-existing condition?_____ Please explain as necessary.
    _____
    _____

DATED THIS_____ DAY OF _____, 20

_____ _____
Physician's Name (please print) Physician's Specialty

_____ _____
Physician's Signature Physician's Street Address

_____ _____
Physician's City/State/Zip Physician's Telephone Number